

State of West Virginia - Public Employees Insurance Agency  
Health Benefits Enrollment Form

HEALTH

Complete this form to enroll for health coverage. Complete all sections of the form except "AGENCY."

EMPLOYEE

Name (Last)				(First)		(MI)		(Generation: Jr., Sr., etc.)		Social Security Number							
Street Address						County of Residence				Home Phone (      )							
City				State		Zip		Job Title		Work Phone (      )							
Sex (Circle One)		Date of Birth (mm/dd/yyyy)		Other Insurance (Plan Name) If Any													
M      F																	
Do you wish to participate in the IRS Section 125 Premium Conversion Plan sponsored by PEIA, if available?										YES				NO			
If you do not wish to participate in any PEIA health coverage, please sign this box and return this form to your benefit coordinator. I decline to participate in the health coverage.																	
Signature:										Date:							

FAMILY INFORMATION

Is spouse currently insured by PEIA as a policyholder? <input type="radio"/> Yes <input type="radio"/> No   If yes, enter spouse's Social Security Number: _____															
Please complete the following information for all dependents who will be covered under your plan:															
Name Last, First, MI, Generation)			Address (If different from above)			Relationship (Circle One)	Sex/ Category	Birth Date		Social Security Number		Other Insurance (Plan Name)			
			.....			SP	CH								
			.....			SP	CH								
			.....			SP	CH								
			.....			SP	CH								
			.....			SP	CH								
CATEGORY for Dependent Child(ren): Relationship Code 1. Child (biological or adopted) 2. Step-child 3. Grandchild 4. Court-Ordered Dependent Child 5. Student (age 19-25) 6. Other In dependent column titled "Sex/Category", please include both gender and relationship code (e.g., M1 for Male Child; F3 for Female Grandchild; F25 for Female Step-child/Student, etc.). If adding a dependent child other than your biological or adopted child, documentation is required showing legal guardianship of the child.															

COVERAGE

COVERAGE SELECTION (Select One) I am enrolling for:						Please indicate the plan in which you are enrolling by checking the box beside the plan option you choose:											
<input type="checkbox"/>		Employee Only				<input type="checkbox"/>		PEIA PPB Plan A				<input type="checkbox"/>		PEIA PPB Plan D			
<input type="checkbox"/>		Employee/Child(ren) Only				<input type="checkbox"/>		PEIA PPB Plan B				<input type="checkbox"/>		The Health Plan HMO Plan A			
<input type="checkbox"/>		Family				<input type="checkbox"/>		PEIA PPB Plan C				<input type="checkbox"/>		The Health Plan HMO Plan B			
<input type="checkbox"/>		Family with Employee Spouse															

AFFIDAVITS

<b>Tobacco Affidavit:</b> Please mark which members of the family use tobacco and sign the form. If none of the people enrolled on your coverage uses tobacco, you will receive the discount on your health and life insurance premiums. I acknowledge by signing the Acceptance box below that WVPEIA or its agents have access to my medical records to check my tobacco use status.															
Who uses tobacco: <input type="radio"/> Policyholder <input type="radio"/> Dependent (spouse and/or children) <input type="radio"/> No Tobacco Users within the last six (6) months															
<b>Living Will Affidavit:</b> PEIA offers a premium discount to health policyholders who have executed a Living Will/Advance Directive. If you have a valid living will, please check the box beside the statement below and sign the form.															
<input type="radio"/> By checking this box, I acknowledge that I have executed a valid Living Will or advance directive, and that I have discussed its contents with the appropriate parties, including my family and my health care provider.															

ACCEPTANCE

I hereby accept the group coverage I have indicated above. I understand that the PEIA may change the types or levels of benefits or the amount of contribution. I certify that the above information is true and correct and understand that providing false information on this form is illegal and that those who provide false information may be prosecuted. I hereby consent, for myself and my covered dependents, to the release to PEIA and to the plan I have selected, of all medical and prescription drug information needed to process claims, determine coverage, review utilization, investigate complaints, assess quality of care, evaluate plan performance or any other process involved in my treatment, payment of claims or health care operations.															
Employee's Signature:										Date:					

AGENCY

Agency Name				Account Number				Date of Employment				
Hours Worked Weekly			Effective Date of Coverage			Index Code		Region		Coverage Code		
I hereby certify that, to the best of my knowledge, the information contained herein is accurate. I further certify that the employee is a permanent full-time employee of this agency who meets the minimum eligibility requirements for the Public Employees Insurance Plan.												
Authorized Signature:										Date:		

Please send the original to PEIA